

Worker's Compensation Questionnaire - Claimant

Claimant Information:

Last Name:

First Name:

MI:

ID or SSN:

(Este es un documento importante. Si usted necesita un intérprete, póngase en contacto con su oficina local.)

Under Section 606 of the Illinois Unemployment Insurance Act, an individual shall be ineligible for benefits for any week with respect to which he/she is receiving or has received payment for temporary disability under the Workers' Compensation Act. Please provide information regarding this payment. The information you provide will be used for the purpose of determining your eligibility for benefits.

Please complete, sign and return this questionnaire to your Illinois Department of Employment Security Local Office as instructed. Failure to respond will result in a determination based on the available information. *If you need additional space, please use the other side of this document, if appropriate, or attach a separate sheet of paper.*

Section A: Workers' Compensation Information

Did you incur an injury arising out of and during the course of your employment? Yes No

Are you receiving compensation under any Workers' Compensation Act? Yes No

What type of workers' compensation payments are you receiving or entitled to receive? (Select one)

Temporary Disability (You must answer remaining questions)

Permanent Partial Disability

Permanent Total Disability

Lump Sum Payment

Other: (Please Explain)

If you did not select 'Temporary Disability', please skip to Section B, no further questions are required.

When did you begin receiving workers' compensation? / /

What is the weekly workers' compensation amount received? \$

When will workers' compensation discontinue?

Section B: Signature

Signature:

Date:

Name (printed):

Telephone Number: